MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2008 01984

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Water St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: aryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: Water St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle Lambert — Last Bacchus

4. DATE OF DEATH: Month Feb. — Day 8. — Year 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 22, 1894

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Antique Dealer

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country): Kent Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jefferson D. Bacchus

14. MOTHER'S MAIDEN NAME: Lousia Lambert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: 063-05-9726

17. INFORMANT: Ethel Bacchus Melamet — Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic cancer lung — INTERVAL BETWEEN ONSET AND DEATH: 6 months

180 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cancer of left kidney (renal cell ca of kidney with skin metastases) — ???
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from November 1960 to February 8, 1961 that (I) (we) last saw the deceased alive on 2-7- 1961, and that death occurred at 10a. M, from the causes and on the date stated above.

22a. SIGNATURE: A. C. Dick M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2/9/61

22c. PHYSICIAN'S NAME (Type): A. C. Dick

22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/10/61

23c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery

23d. LOCATION (City, town, or county) (State): Chestertown, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: FEB 14 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2009 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01985

1. PLACE OF DEATH
e. COUNTY: Kent
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 18 hours
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kent & Queen Annes

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Millington (rural)
d. STREET ADDRESS: X
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First GEORGE Middle LEONARD Last COFFMAN

4. DATE OF DEATH: Month February Dey 28 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: June 6 1942

9. AGE (In years last birthday): 18 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Earl G. Coffman

14. MOTHER'S MAIDEN NAME: Ethel Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

16. SOCIAL SECURITY NO.: 216 49 4116

17. INFORMANT Address: Earl Coffman, Marydel, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 835 X

DUE TO (b): Extensive electrical burns (high voltage) involving left arm and leg, lumbar area of back, and also to a lesser degree the right arm & leg

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 19 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) drove a tractor into a pole and caused hi-tension wires to fall, catching under tractor and preventing his removal for about 15 minutes. Current did not stop.

20c. TIME OF INJURY Month, Dey, Year: Hour 3:15 p.m. 2/27/61

20d. INJURY OCCURRED at work [X] not at work [ ]

20e. PLACE OF INJURY (Home, farm, etc. City or town) (County) (State): farm near Millington, Md, Kent

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Robert W. Farrr M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: 2/28/61

EXAMINER'S NAME (Type): Robert W. Farrr

Address (Street, city, town, or county): Chestertown, Kent, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/2/61

22c. NAME OF CEMETERY OR CREMATORY: Baldwin Cemetery

22d. LOCATION (City, town, or country) (State): Rural Sudlersville Md.

23. FUNERAL DIRECTOR: Edward Tilbur ADDRESS: Millington Md.

24a. REC'D BY REGISTRAR DATE: MAR 3 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

x

x

x

x

x

x

x

x

x

x

x

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2010

01986 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Kennedyville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Kennedyville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Mary Middle E. Last Comegys

4. DATE OF DEATH: Month Feb. Day 22 Year 19 61

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: June 20 1882
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeping
10b. KIND OF BUSINESS OR INDUSTRY: farm home
11. BIRTHPLACE (State or foreign country): Kent Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nicholas George
14. MOTHER'S MAIDEN NAME: Amanda Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.:
INFORMANT Address: Mrs. Chas. Olin Powell Kennedyville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cholangitis — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
DUE TO (b): Cholecystitis — INDEF
DUE TO (c): Cholelithiasis — INDEF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

584 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Palpable Nodes on Liver - possible Metastatic Ca
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/22/ 1961, to 2/23 1961, that I last saw the deceased alive on 2/22 1961, and that death occurred at 7A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas J Solon M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 2/25/61

PHYSICIAN'S NAME (Type): Thomas J. Solon — Chrstertown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/25/61
22c. NAME OF CEMETERY OR CREMATORY: Kennedyville Cemetery
22d. LOCATION (City, town, or county) (State): Kennedyville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: FEB 27 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2011 — Reg. Dist. No. 01987

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): near Kennedyville
c. LENGTH OF STAY IN 1b: Short
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Railroad Eng. Accident (Penna. RR)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Delaware — b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
d. STREET ADDRESS: 606 Jewell St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Carlas — Last: Dickerson

4. DATE OF DEATH: Month: Feb. — Day: 5, — Year: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/4/1918

9. AGE (In years last birthday): 42 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Penna. R. R. Engineer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Dickerson

14. MOTHER'S MAIDEN NAME: Amanda Givens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W W 2

16. SOCIAL SECURITY NO.: 717-12-5143

17. INFORMANT — Address: Geraldine Dickerson, Delmar, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Crushing injuries to chest & abdomen — INTERVAL BETWEEN ONSET AND DEATH: immediate

800 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): was crushed as result of RR. derailment

20c. TIME OF INJURY: Hour ~~a.m.~~ p.m. — Month, Day, Year: 8:30 p.m. 2/5/61 19

20d. INJURY OCCURRED While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Railroad

20f. (City or town) (County) (State): near Kennedyville Kent Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Robt W Farr M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ XX

EXAMINER'S NAME (Type): Robert W. Farr

DATE SIGNED: 2/6/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-9-61

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olive

22d. LOCATION (City, town, or county) (State): Delmar, Del.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. L. Mansfield Co - Delmar, Del

24a. REC'D BY REGISTRAR DATE: FEB 8 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Keene

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director who should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2012

CERTIFICATE OF DEATH

01988

1. PLACE OF DEATH
a. COUNTY Kent MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bettertown
c. LENGTH OF STAY IN 1b 21 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bettertown
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: William Henry Middle: Last: Fleckenschildt

4. DATE OF DEATH Month: Feb. Day: 16, Year: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 13, 1888

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wholesale Meats

10b. KIND OF BUSINESS OR INDUSTRY: retired

11. BIRTHPLACE (State or foreign country): Baltimore City

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Fleckenschildt

14. MOTHER'S MAIDEN NAME: Margaret Boggs.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-18-8700

17. INFORMANT: Mrs. Edgar Harris Address: Chestertown, Md. daughter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 1 minute
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Old coronary artery disease — 10 years
DUE TO
(c)

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July 1955, 19__, to ____, 19__, that (I) (~~we~~) last saw the deceased alive on Nov 8 1960, and that death occurred at 3:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE Florence D. Joyce M.D.

ATTENDING PHYS. XX MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 2/17/61

22c. PHYSICIAN'S NAME (Type) Florence D. Joyce

22d. ADDRESS RFD Worton Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF Feb. 20, 1961

23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery

23d. LOCATION (City, town, or county) (State) Chestertown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells

ADDRESS Chestertown, Md.

25a. REC'D BY REGISTRAR DATE FEB 23 '61

25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2013 0198

1. PLACE OF DEATH
a. COUNTY Kent MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynch
c. LENGTH OF STAY IN 1b 9 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lynch
d. STREET ADDRESS ~~Main St.~~ Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last: William Webster Hadaway

4. DATE OF DEATH Month Day Year: Feb. 27, 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 14, 1890

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Automobile Mechanic (laborer)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel Hadaway

14. MOTHER'S MAIDEN NAME: Alice Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 216-01-6062

17. INFORMANT: Mrs. Wm. Webster Hadaway Address: Lynch, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs 40 min

331X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/27 1961, to 2/27 1961, that (I) (we) last saw the deceased alive on 2/27 19 61 and that death occurred at 3:40 PM, from the causes and on the date stated above.

22a. SIGNATURE Robert W. Farr M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED Feb. 28, 1961

22c. PHYSICIAN'S NAME (Type) Robert W. Farr

22d. ADDRESS Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF Mar. 2, 1961

23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery

23d. LOCATION (City, town, or county) (State) Chestertown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.

25a. REC'D BY REGISTRAR DATE MAR 2 '61

25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2014 01890

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b: one-half hr.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne's Hospital

d. STREET ADDRESS: 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Minnie Middle Last Phillips

4. DATE OF DEATH: Month 2 Day 1 Year 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): DELAWARE

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-14-2801

17. INFORMANT: WM. LEARY Address: ROCK HALL MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Auto Exposure to Weather
DUE TO
932.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/1/61 19__ to 2/1/61 19__, that (I) (we) last saw the deceased alive on 2/1/61 19__, and that death occurred at 1 M, from the causes and on the date stated above.

22a. SIGNATURE: Wm. M. Gatewood M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): WILLIAM GATEWOOD

22d. ADDRESS: Rock Hall, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/4/61

23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel

23d. LOCATION (City, town, or county) (State): Rock Hall Md

24. FUNERAL DIRECTOR'S SIGNATURE: Edgar L Lane ADDRESS: Chuck Hall Md

25a. REC'D BY REGISTRAR DATE FEB 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0199

1. PLACE OF DEATH
a. COUNTY: Kent
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kent & Q een Annes

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sudlersville(rural)
d. STREET ADDRESS: 17X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Earl; Middle: ; Last: Spencer

4. DATE OF DEATH: Month: 2; Day: 20; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/25/31

9. AGE (In years last birthday): 29 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Chicken factory

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Spencer

14. MOTHER'S MAIDEN NAME: Martha ~~Weat~~ Beale

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): Korean

16. SOCIAL SECURITY NO.: 219-34-6625

17. INFORMANT: Hospital Records, Chestertown, Md.
Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Central nervo s system damage	30 ho rs
DUE TO (b)	Carbon monoxide poisoning	30 hours
DUE TO (c)	Was found in his one room home about 9:30 AM 2/20/61	

890.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

& was brot to hospital in an Un conscio s state. Never regained con-
scio sness and died in terminal hyperpyrexia abot 30 hrs later. A coal
heater was discharging gass into the room.

19. WAS AUTOPSY PERFORMED? ☐

MEDICAL CERTIFICATION

20a. WAS OPERATION PERFORMED FOR PRIMARY OR CONTRIBUTING CAUSE OF DEATH? ☒

20b. IF OPERATION, DATE OF OPERATION (Month, Day, Year)

20c. TIME OF INJURY: Hour: 9:30 e.m. ☒ Month, Day, Year: 2/20/61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

20f. (City or town): Sudlersville (County): QA (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert W Farr M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Robert W. Farr

Address (Street, city, town, or county):

DATE SIGNED: 2/21/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 23, 1961

22c. NAME OF CEMETERY OR CREMATORY: Sudlersville Cemetery

22d. LOCATION (City, town, or country): Sudlersville (State): Md.

23. FUNERAL DIRECTOR: Edward Fellows

ADDRESS: Millington, Md

24a. REC'D BY REGISTRAR: DATE: FEB 24 '61

24b. REGISTRAR'S SIGNATURE: Arthur S Krauss

x x

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2016 CERTIFICATE OF DEATH

Reg. Dist. No. 0199

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R. D. 1 Chestertown
c. LENGTH OF STAY IN 1b: 44 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: -----

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R. D. 1. Chestertown
d. STREET ADDRESS: -----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lydia Middle Virginia Last Whittington

4. DATE OF DEATH: Month February Day 11 Year 19 61

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 28, 1895

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.:

INFORMANT Address: Ruth Whittington, Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 hours

331X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (b): Atherosclerosis, Hypertension — years
DUE TO (c): Atherosclerosis Generalized — years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive Heart Failure. / 2 Previous Strokes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Yeor 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/30, 1958, to 1/31/61, 1961, that I last saw the deceased alive on 1/31/61, 1961, and that death occurred at 1:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN: Thomas J. Solon M.D.
ADDRESS (Street, city or town, state): Chestertown md.
DATE SIGNED: 2/11/61

PHYSICIAN'S NAME (Type): Thomas J. Solon
Chestertown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/14/28
22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery
22d. LOCATION (City, town, or county) (State): Still Pond, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy
ADDRESS: Still Pond, Md.

24a. REC'D BY REGISTRAR DATE: 2 14 61

24b. REGISTRAR'S SIGNATURE: Clarence E. Frame

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2017

CERTIFICATE OF DEATH

Reg. Dist. No. 01993

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 4 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Duyer Apts.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Chestertown
d. STREET ADDRESS: 1 Duyer Apts. Mapel Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ X

3. NAME OF DECEASED (Type or print): First Jennie — Middle — Last Wilkins

4. DATE OF DEATH: Month Feb. — Day 27 — Year 19 61

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 29 1873
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeping
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Chestertown Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Mifflin Wilkins
14. MOTHER'S MAIDEN NAME: Mary Anna Merritt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: none
INFORMANT: Miss Grace Wilkins — Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

410 X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (b): Mitral insufficiency — 6 months
DUE TO (c): Old rheumatic heart disease ??

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 12-1, 1960, to 2-27, 1961, that I last saw the deceased alive on 2-26, 1961, and that death occurred at 3:40a.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A C Dick M.D.
ADDRESS (Street, city or town, state): Chestertown, Md.
DATE SIGNED: 2-27-61

PHYSICIAN'S NAME (Type): A. C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 1/ 61
22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE MAR 6 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
15M 9/58